BERK & ASSOCIATES

Financing Local Public Health in Washington State: Challenges and Choices

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PHIP Finance Committee
Berk & Associates

In the last decade, local funding to support local public health services declined 27%, a drop of $22.3 million, in the 34 jurisdictions outside of King County (2005 dollars).

Everyone in Washington State relies on its government public health system for protection against environmental dangers and diseases, including major outbreaks that could cause widespread harm to the state's people and economy. The system's financial structure, however, prevents it from adequately performing these essential functions. This document summarizes the financial and policy analysis conducted by the Public Health Improvement Partnership Finance Committee, with the assistance of Berk & Associates, over the last four years. It is intended as a resource to help policy makers understand the financial difficulties facing the public health system in Washington.

This document is limited to consideration of local public health financial issues. A brief description of Washington's public health system is provided on page 16 of this report and in-depth information is available in the Public Health Improvement Plan (http://www.doh.wa.gov/php).

Public Health for Washington, in a Changing World

Protecting people's safety has long been government's primary purpose. Like law enforcement and fire protection, public health protection is an essential component of public safety and a unique government role. Public health efforts—from the taming of tuberculosis, to the eradication of polio, to the mitigation of diseases caused by poor water quality—have historically been responsible for vast improvements in life expectancy and quality of life. The public health system continues to serve the people of Washington by enforcing safety standards, preventing outbreaks, and collecting data to inform personal and policy decisions.

Maintaining a strong public health system is necessary to keep known diseases at bay, and doubly important for anticipating and meeting the emerging health threats that follow major changes in our world. In evaluating the way public health services are funded, it is important to understand these changes, which include:

Greater mobility. An increasingly mobile world population helps infectious diseases travel farther and faster than ever. A single outbreak, anywhere in the world, could quickly bring severe consequences to Washington State. In 2003, an outbreak of SARS in China spread to Toronto within weeks. That city's public health system was unable to contain the outbreak and the resulting fear was enough to effectively shut down the city. The final cost: 44 deaths, 438 probable and suspected SARS cases, and economic damages to the city estimated at $1 billion (Canadian). There is no reason SARS could not be spread to Washington, and the same is true for other emerging diseases such as Avian Flu.

Resistant strains. Some old diseases that had long been thought conquered—including tuberculosis (TB), gonorrhea and staph infection—have re-emerged in new strains that are dangerous because of their resistance to multiple antibiotics. In 2003, Seattle public health experts scrambled to stop a large outbreak of resistant TB among Seattle's homeless population. The outbreak ultimately encompassed 44 cases, and was prevented from spreading further only through the intensive screening and testing of high-risk individuals, which required additional staff and funds. Similarly, several unrelated cases of active TB were found in Snohomish County in June 2005. Resistant strains have been implicated in at least one case, and the investigation and response have already involved over 50 staff—almost a quarter of the county's public health workforce.

Bioterror threats. Since 2001, the threat of a terrorist attack using smallpox, anthrax or other biological weapons has been widely recognized. Public health agencies would be on the front lines in the event of such an attack, and the probable damage would increase sharply with each passing hour before their response. It is therefore imperative that a robust surveillance system be in place to quickly detect biological incidents, and that the public health system be fully prepared to respond to them.

Funding Public Health in Washington: Past and Present

Washington's 35 local health jurisdictions (LHJs) provide the bulk of government public health services in the state. In 2004, the LHJs spent a combined total of about $370 million. (By comparison, spending on law enforcement and criminal justice by the state's cities and counties totaled $1.93 billion.) The revenues to fund LHJs' services have always come from a combination of local, state and federal funding, but the mix of these funds and the conditions attached to their use have changed significantly over time.

Prior to 1976, a portion of the local property tax everywhere was set aside for general public health and tuberculosis control. In 1976, this standard contribution was repealed by the state Legislature, and city and county decisions came to determine local funding of public health. The result was that, over time, spending came to vary widely from one jurisdiction to another. Dedicated funding would not return until 1996, when legislation went into effect to release cities from their public health funding responsibilities and assigned a portion of the new state Motor Vehicle Excise Tax (MVET) for public health use. The new source actually fell $7 million short of

what would have been the cities' share, but the Legislature made up about 50% of the difference in a series of special appropriations. Since LHJs were held to their historic funding levels, the variation among them continued.

In 2000, following voter approval of the tax-limiting Initiative 695, the Legislature voted to repeal the MVET. Appropriations from the state General Fund restored 90% of the lost public health funds, but the stability of a dedicated funding source was gone and, overall, the public health budget was short by more than $2.5 million per year. In 2001 the Legislature again used special appropriations to make up 90% of the difference, and it has made an equal appropriation—without adjustments for inflation or population growth—in each biennium since.

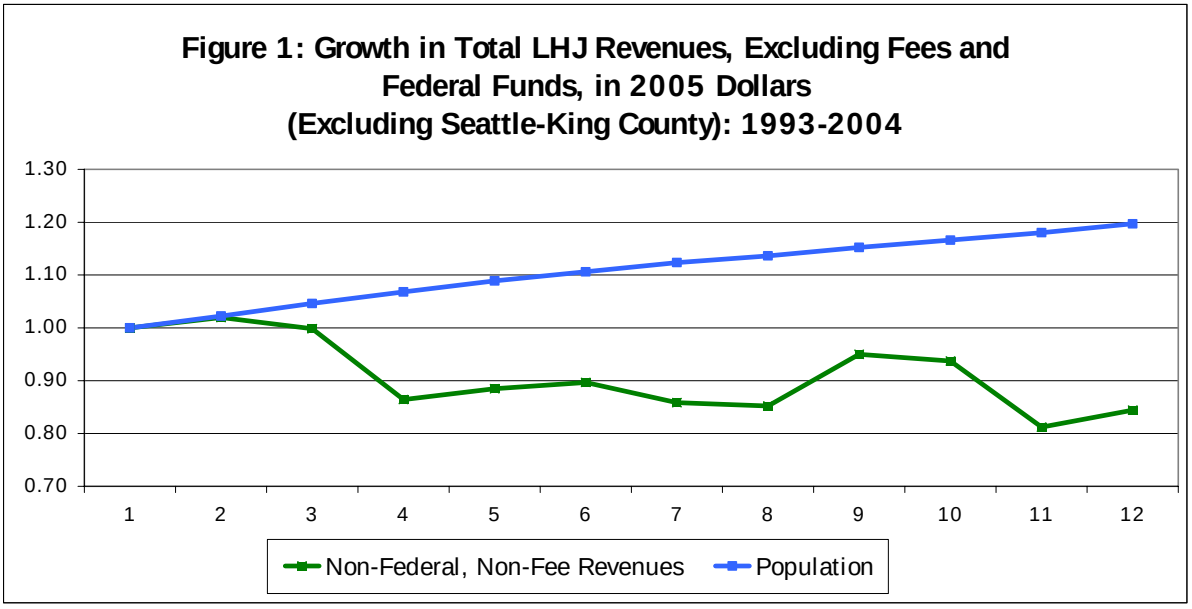
One constant over the years has been the great variation between the Seattle-King County Health Department and any other local jurisdiction. Of the 35 LHJs, Seattle-King County serves the population that is the largest, with greatest density, diversity and number of high-risk individuals. It also provides the broadest scope of services and the only comprehensive primary care services provided by any local public health agency in the state. In 2004, public health expenditures by Seattle-King County totaled $185 million, or 53% of total spending by all LHJs in the state. Because Seattle-King County is so unique and so influential on statewide statistics, and because it employs a different way of categorizing the funds it receives, this paper does not include revenue totals from Seattle-King County.

Today's system for financing public health in Washington has several noteworthy aspects:

- No dedicated, stable funding
- Declining local revenue
- Emerging health threats
- Reliance on categorical funds
- Increasing reliance on fees
- Local funding disparities

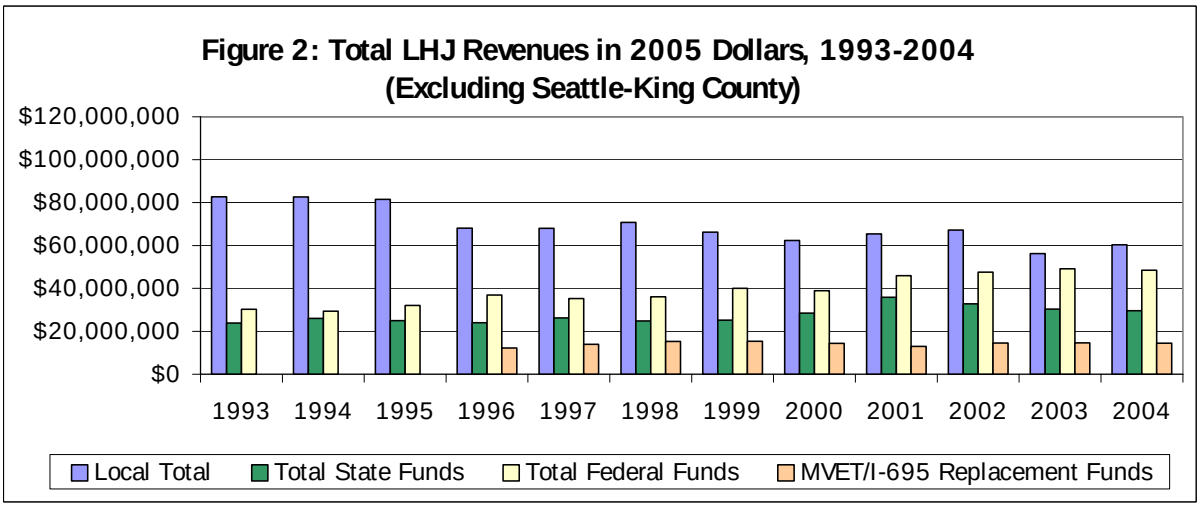
No dedicated, stable funding. The local property taxes assessed before 1976, and the MVET dollars collected in the late 1990s, both provided a dedicated and stable funding source for public health. Since 2000, however, the public health system has depended on budget appropriations made by the Legislature every two years from the state's General Fund. There is no longer a revenue source dedicated to public health, nor a clear expectation of steady funding over time.

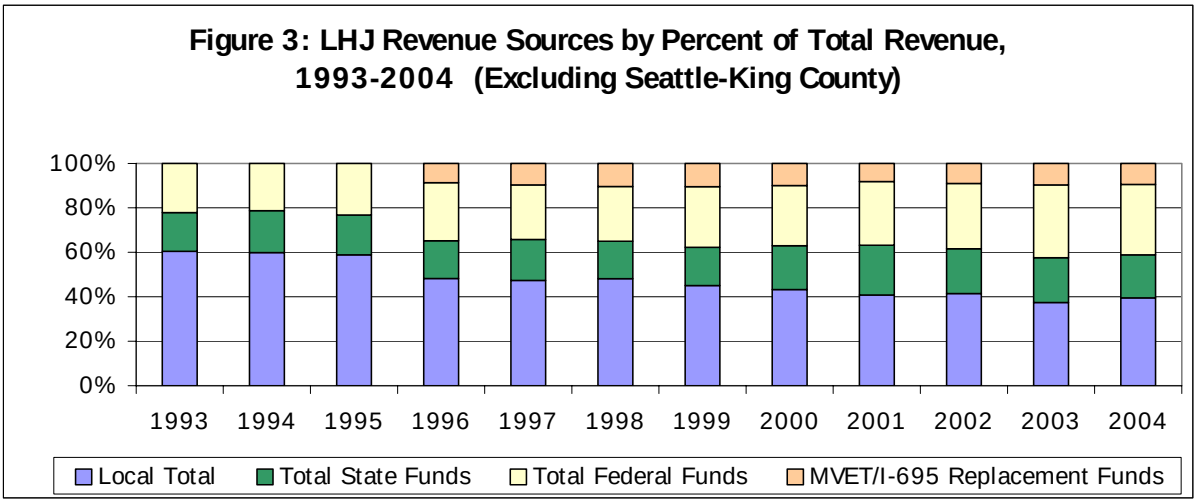
Between 1993 (the first year for which detailed data are available) and 2004, total state and local revenues for public health (excluding license and fees) grew at rate that consistently lagged behind population growth. As Figure 1 illustrates, moreover, revenues also fluctuated during that time. Volatility in funding makes it difficult for LHJs to meet service needs and maintain and trained and ready workforce.



Declining local revenue. The mix of sources for public health funding has shifted since 1993, with a greater share of funding now coming from the state level and a smaller share coming from local sources. Local funds in this analysis are taken from each county's BARS report and include local tax funds. However, in some cases the figure also includes state and federal grants which the local government passes along to the health department or district. Further analysis would need to be done to separate all state and federal sources of funds.

Between 1993 and 2004, in the 34 LHJs outside of King County, the absolute amount of funding from local sources dropped from $82.7 million to $60.4 million (2005 dollars), a decline of 27% (Figure 2). The share of local funding also decreased (outside of King County,) with local contributions dropping from 60% of LHJ budgets to 39%, while state revenues (including special appropriations) grew from 19% to 29% (Figure 3).





Emerging health threats. Stability is not the only characteristic of public health funding that has changed since 1976. Public health agencies' responsibilities have grown significantly. The responsibility to be ready for emerging health threats has become more demanding with the changes in the world described above: greater population mobility, and new threats from antibiotic-resistant disease and bioterrorism. LHJs must now also spend revenue to fulfill a variety of other new and expanded duties, including:

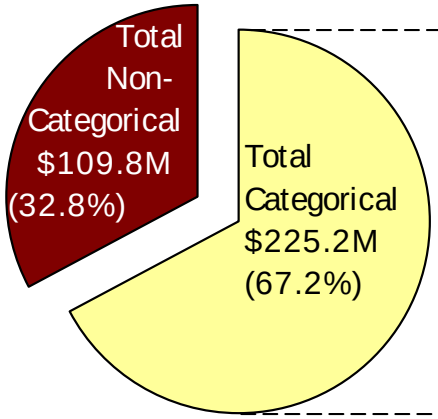
- cleaning up dangerous methamphetamine labs;
- enforcing more stringent food codes;
- administering new vaccines; and
- monitoring and preventing many new and emerging diseases.

One more new responsibility—to enforce a new set of complex rules for residential septic systems—is also anticipated for the near future.

Reliance on categorical funds. Most of the funding for public health in Washington comes with strings attached, in restricted, category-specific grants and revenues. As Figure 4 illustrates, two out of three dollars spent by LHJs in 2004 were derived from a categorical source. Figure 5 shows the categorical expenditures from each source: federal grants, state grants, Medicaid (federally and state supported), and local licenses and fees.

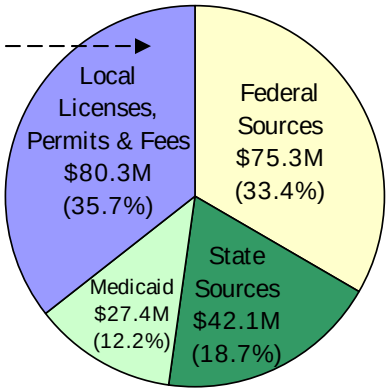
Categorical funds often arrive in small amounts and are available only for very specific purposes—not for alleviating the underlying causes of public health problems. Thus, while valuable, categorical funds do not directly improve LHJs' ability to provide "core" public health services, such as detecting and preventing infectious disease, and assuring the cleanliness of food and drinking water. Categorical dollars may provide indirect support to core services in some cases, but the benefit of such "spillover" capacity is limited and does not substitute for direct funding. Furthermore, categorical funds are not always reliable—especially at the federal level. Tightening Medicaid rules, a White House budget proposal that would eliminate preventive health block grants to states, and a looming deficit all suggest a coming downturn in federal support for public health.

Figure 4: Total LHJ Expenditures in 2005 Dollars, by Source Type, 2004



Total: $335 million

Figure 5: Categorical LHJ Expenditures in 2005 Dollars, by Source, 2004



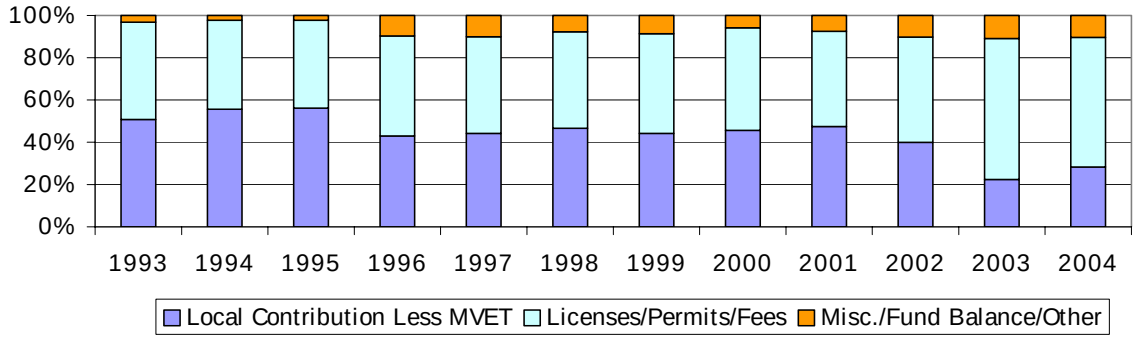
Total: $225.2 million

Expenditures by Seattle-King County Health are included in figure 4. Non-categorical funding comes from local government tax revenue and two state-level sources: local Capacity Development Funds, and "backfill" tax dollars appropriated to replace MVET funds. Categorical restrictions are greater than they appear, because some of the local government contributions are state and federal grants passed along by local government – and they carry spending restrictions.

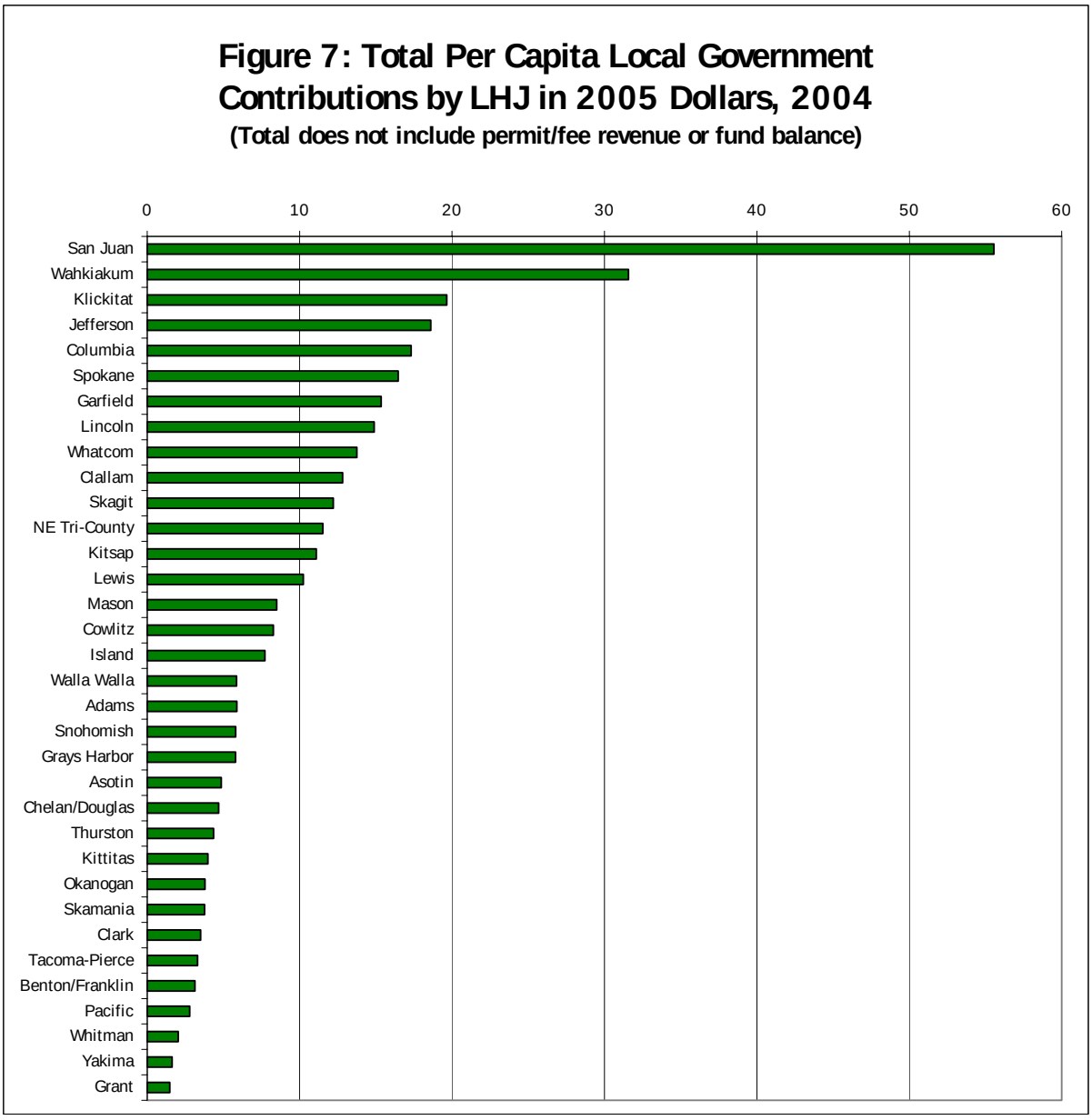
The public health system's reliance on categorical funding poses a dilemma to the local health officials: restricted funds can provide staff for a special purpose, but those staff are not free to address the core needs that are most pressing in a local community. Thus an agency with personnel available may still not be able to use a staff member—such as a bilingual nurse—to provide the services the area seems to need the most. Categorical health priorities have also been known to hinder one another. When the federal government provides bioterrorism training opportunities, for example, LHJ staff may be unable to attend because their positions are funded for a different specific activity (and may be needed to generate fee revenues).

Increasing reliance on fees. At the local level, categorical funds come from license, permit and other fees. Unlike taxes, which are paid by a broad public base, fees are charged to individual businesses, and perhaps their customers by extension. By law, fee revenue must only fund the service for which the fee was charged, and must not exceed the cost of the service. Fees can also be difficult to increase once established. As Figure 6 illustrates, license and fee revenues have been providing an increasing share of local revenues for LHJs outside of King County. (This trend is not evident in King County.) For the LHJs, this means greater reliance on an especially inflexible form of funding.

Figure 6: Local Revenue Sources by Percent of Total Revenue, 1993-2004 (Excluding Seattle-King County)



Local funding disparities. Since 1976, large disparities have emerged in the levels of local funding provided to different LHJs across the state—and, by extension, in the levels of service each can provide. The unique circumstances at each LHJ make individual comparisons difficult (and every budget is constructed differently), but Figure 7, next page, illustrates the great overall variation in per capita revenue provided by local governments in 2004. Three LHJs received $30-55 of local government funding per resident that year, while nine others received less than $4 per resident (2005 dollars).



Funding Challenges

The above factors together have raised major financing challenges for Washington's public health system. For the system to adequately carry out its work of improving and protecting health and safety around the state, its budget and financing system must do the following:

Facilitate funding decisions based on objective standards. Effective funding decisions, and true public accountability for public health spending, both require a reference point: what is it that every public health jurisdiction should be doing and accomplishing? What should residents, taxpayers and leaders have a right to expect? These are pressing questions, best answered by a set of deliberate, objective and uniform standards for public health in Washington.

Provide stable and dedicated funding. A robust public health system delivers essential community health services; saves individuals and communities from the suffering and disproportionate expense of preventable disease; and actively prepares for potentially devastating health threats. Maintaining such a system is a long-term investment, made in the most effective and stable form when particular revenue sources can be *dedicated* to maintaining the public health system's core capacity.

Without a dedicated funding source, there is no assurance that core public health services will continue, without deterioration, from year to year. Public health protection is akin to law enforcement and fire protection in this respect: all three are constant public needs that reward sustained and forward-looking investments, and that can rise to critical importance at any given moment.

When public health funding is uncertain, effective management and planning becomes quite difficult. Any effort requiring longer-term investment risks being curtailed before completion, and the general uncertainty can complicate even simple decisions. In one Washington county, for example, county officials have pressured the LHJ to use special Legislative appropriations only for one-time projects, on the grounds that funding regular services could lead to unfunded public expectations in the next biennium.

Support public health consistently across the state. Local public health services will always reflect the values and priorities of local communities, but the current pattern of health protection across the state is marked by extreme disparities. This poses a problem not only for equity but for system performance. Diseases do not respect jurisdictional boundaries, and in the event of a broad threat to public health, a "weak link" at one jurisdiction could put thousands at risk elsewhere in the state.

Employ efficient structures and systems. Washington's large network of local health jurisdictions has important benefits for the on-the-ground business of assessing and assuring the health and safety of local communities. Nevertheless, those advantages must be weighed against the inefficiencies of providing core services through what some have called a "patchwork" of different entities with widely varying sizes, services, needs and priorities.

The Cost of Basic Public Health

Washington's public health officials have responded to these challenges by developing standards about public health services. Without a clearly stated set of standards, it is impossible to do the important work of measuring performance. State and local health officials have worked together to create a draft set of standards for which they, at the state and local levels, are mutually accountable. The standards describe what public health professionals in this state believe everyone has a right to expect of the governmental public health system. The first standards were field-tested in 2000, used in a baseline measurement of the entire system in 2002, and clarified in 2004. Measurement is underway in 2005, with performance results

expected in the fall. The standards represent basic protection that should be in place everywhere, in five key aspects of public health:

- **Understanding health issues** through data collection and analysis;
- **Protecting people from disease** through disease surveillance, case investigation and control measures;
- **Assuring a safe, healthy environment for people** through food, water, waste and other regulation for safety;
- **Promoting healthy living** through locally-focused health promotion activities; and
- **Helping people get the services they need** through assessment, referrals, and some direct services.

The baseline test identified some standards that are already being met, as well as some that are expected to remain unattained for a number of years. Unmet standards are especially prevalent in environmental health and access ("helping people get the services they need"), two areas where resources were thin for service and follow-through. The evaluation process involves feedback and collaboration with the LHJs, which are then prepared to take whatever corrective steps they can given the resources available. Measures for state level performance are also included, emphasizing the fact that public health is a mutually dependent and mutually accountable *system*.

With the standards and baseline results in hand, work began in the effort to estimate the cost of bringing the entire state up to a basic level of service, an exercise the Legislature required when it established the PHIP. Consultation with local and state public health staff and sophisticated cost-model methodologies were used to approximate the size of the "gap" between current funding levels and the resources necessary to meet the standards. Cost estimates were based on the costs for providing specific services, described in Appendix A, and categorized by Standards topic area, Appendix B. The cost models took into account jurisdictional size, but did not attempt to parse public health costs under any possible re-organization. The conclusion: To meet the standards 95% of the time throughout the state would require a sustained annual investment of about $400 million, in addition to current resources—$15 million for the state Department of Health and $385 million for the LHJs.

This was a first attempt to gauge the cost of providing similar public health services statewide and additional work needs to be done to specify and prioritize costs. Establishing a predictable level of public health services throughout Washington will not be inexpensive, but it is possible—and critically important. With an objective approach to costs and performance, a stable and dedicated funding source, and a hard look at equity and efficiency across the state, the people of Washington could rely on a public health system.

Sources

PHIP Finance Committee. Personal interviews. June 2005.
Public Health Improvement Partnership, *Public Health Financing for the 21st Century*. Feb 2005.
Washington State Budget, Accounting and Reporting System (BARS). Accessed June 2005.
Washington State Department of Health, *2004 Public Health Improvement Plan*.
Washington State Department of Health, *2002 Public Health Improvement Plan*.
Washington State Office of Financial Management Historical Population Data. Accessed June 2005.

Appendix A: Public Health Services

What are the services that a mid-size health jurisdiction must provide to achieve 95% performance according to the Washington Public Health Standards?

ASSURING A SAFE AND HEALTHY ENVIRONMENT

- Food Safety (inspections, education, permitting, data management including local responsibilities for shellfish monitoring)
- Water recreational facility safety (inspections, education, permitting, data management)
- Hazardous Materials Management (drug lab inspection, testing oversight, clean-up oversight)
- Solid Waste Management (permitting, inspection, enforcement, education)
- Water Quality Control: sewage (permitting, inspection, enforcement, education and O&M), ground water, drinking water (permitting, inspection, enforcement, education, DW data), surface water (DW permit, inspection, enforcement, education, environmental monitoring
- Vector/Rodent Control/Zoonotic Disease (inspection, enforcement, education, sampling)
- Air Quality Monitoring (indoor investigations)
- Environmental Laboratory Services
- School Safety (inspection, education, consultation)
- Environmental Health Community Involvement
- Environmental Sampling
- Review of Land Use Decisions

PROTECTING PEOPLE FROM DISEASE

- Detection/Case Investigation: screening (specimen collection and analysis), testing, lab (identification and diagnosis), diagnosis (clinical and lab identification)
- Surveillance, Reporting (transmission of information), Data Analysis (monitor and interpret), Data Gathering (collecting information and collection systems), Epidemiological Investigations, Case Finding (identifying cases and location), Contact Tracing (identifying potential exposure)
- Regional Epidemiology
- Laboratory (identification and diagnosis)
- System Intervention: immunizations (preventive pre-or post-exposure), treatment and prophylactic treatment (dispensing, shots, application, observation), counseling (one-on-one education and therapy), TB Program
- Public and Provider Education (informing general public and outbreak specific)
- Surveillance of chronic disease trends and behavioral changes (identification of clusters, special studies to identify risk factors and focus prevention efforts, prevention activities focused on behavioral and environmental/policy interventions, and evaluation)
- Outreach and prevention with high-risk populations
- Plans and surge capacity for response to emergency situations that threaten the health of people

UNDERSTANDING HEALTH ISSUES

- Epidemiology (infectious and non-infectious disease trends monitoring, collection and analysis of data on health risk behaviors, health status and critical health services)
- Dissemination of assessment information in the community to support decision making
- Technical assistance, education and leadership for community-level data utilization
- Evaluation of public health program results

PREVENTION IS BEST: PROMOTING HEALTHY LIVING

- Capacity for health education and systems-work related to the following activities: engaging community agencies, organizations and constituencies to address and develop locally designed programs driven by locally identified health issues, strategic planning based on community needs, local data gathering and analysis, coalition and stakeholder building
- Resource assessments (develop assessment of resources based on specific needs), generate resources (design materials, find funding, write grants), designing and providing promotional materials, and/or social marketing campaigns evaluating results of efforts, collecting and disseminating research-based best practices
- Assure and support healthy pregnancy, healthy birth outcomes, early brain development. Includes maternal & child health programs, early intervention, health and safety promotion in child care centers, children with special health care needs, family planning, First Steps/MCM/MSS community outreach and WIC
- Evaluating results of efforts, collecting and disseminating research-based, replicable best practices (including about chronic illnesses and health behaviors), provider and public education

HELPING PEOPLE GET THE SERVICES THEY NEED

- System assurance: Bring people together and provide leadership and support, system infrastructure, support for local community SWOT Assessment.
- Provide information and education about critical public health services. Create conditions that make action possible.
- Information and referral activities (maintain inventory of services, referral, resource broker)
- Create conditions that make action possible (standards, policy, QA, materials and supplies, information and education).
- Safety net services (direct services as identified through local assessment, menu of critical services)

ADMINISTRATION

- Leadership, planning, policy development and administration
- Financial and Management Services (accounting, budget, contracts, procurement, grants, asset management)
- Leadership and Governance (communication, PR, relationship building, program planning, fundraising)
- Legal Authority (policies, procedures, regulations)
- Human Resources (personnel, employee development and recognition, compensation and benefits management, employee policies)
- Information Systems (hardware/software systems, networking, data sharing, policies)

Appendix B: The Cost of Meeting the Standards

How much would it cost for all health jurisdictions to achieve 95% performance according to the Washington Public Health Standards?

The PHIP Finance Committee's effort to "cost the standards" generated estimates of the annual funding that would be required to bridge the gap, in each of five topical service areas, between what health jurisdictions currently provide and what they would need to provide to achieve 95% performance according to the standards. These figures (presented in Table B-1) are strictly estimates, based only on the system needs that local and state health officials know of today.

Table B-1: Estimated Annual Cost of Meeting the State Public Health Standards, by Topical Area

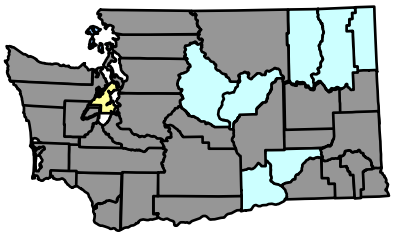
Area of Public Health Service	*Estimated Cost (thousands of dollars)*	*% by Topic*
Assessment	$23,039	6%
Communicable Disease	$98,651	25%
Environmental Health	$110,622	28%
Prevention and Promotion	$129,986	32%
Access to Critical Health Services	$37,702	9%
Total	$400,000	100%

Source: Public Health Improvement Partnership Finance Committee

Appendix C: Local Public Health in Washington State

Organization

Washington has 35 local public health jurisdictions, all of which are either departments within county governments or separate districts, established under county authority. Three districts encompass more than one county: Benton-Franklin, Chelan-Douglas, and Northeast Tri-County (covering Ferry, Stevens and Pend Oreille Counties).



A local Board of Health oversees each health department or district. Some Boards are comprised of three county commissioners, others include a mix of county and city representatives and a few have included one or two non-elected representatives. By law, the majority of the Board of Health must be elected.

Population served

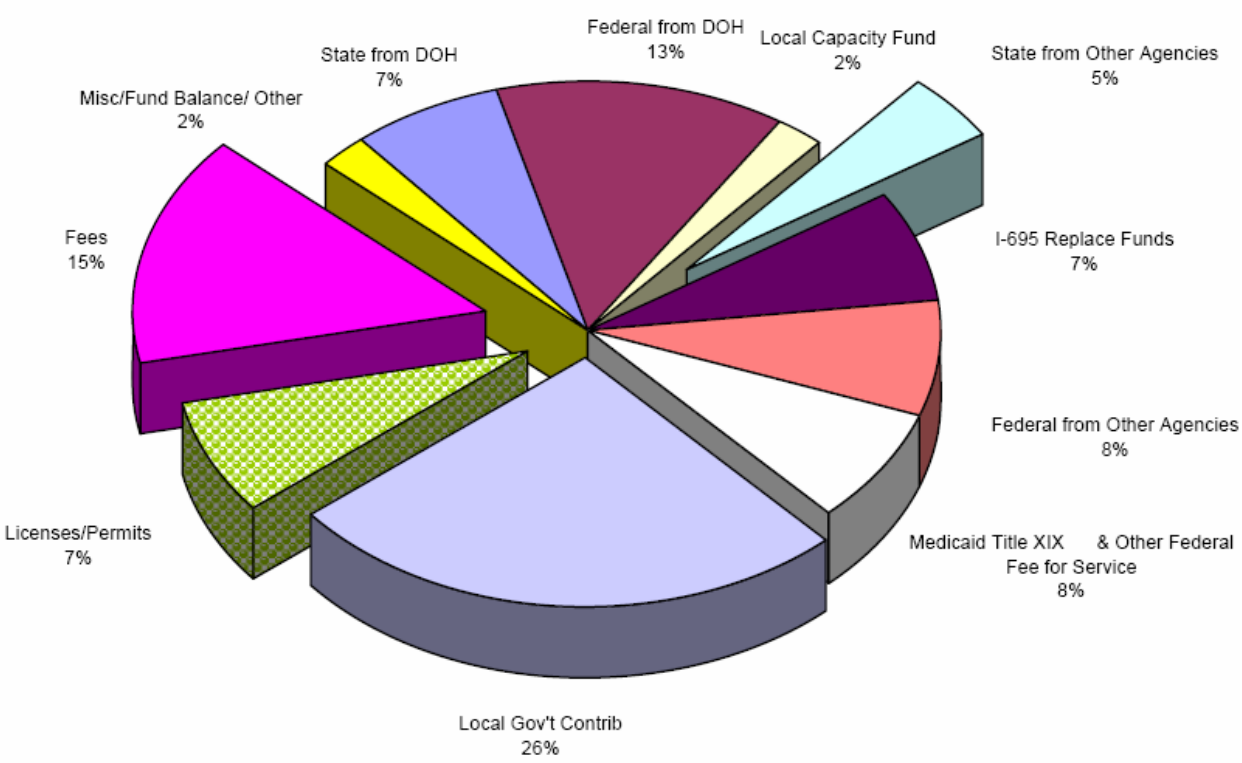
The smallest health department, in Garfield County, serves 2,400 people. The largest, Public Health Seattle-King County, serves 1,788,300.

Funding

In 2004, local health jurisdiction revenues were $349,792,798. (see Sources, p. 17)

Health departments and districts rely on a mix of local, state and federal funding. Local funding comes from general tax revenue, plus revenues from licenses, permits and fees at the local level. Federal funds come from grants for specific programs or as reimbursement for performing specific services. About 20% of funds come from state government, and about two-thirds of those are linked to specific programs.

Figure C-1: Funding of Local Health Services in Washington, by Source, 2004



Source: Washington State Budget, Accounting and Reporting System (BARS), DOH.